

		FOR OHF USE					

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2002
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR
LONG-TERM CARE FACILITIES
(FISCAL YEAR 2002)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

<div>I. IDPH Facility ID Number: 0040535</div> <div>Facility Name: HARMONY NURSING AND REHAB</div> <div>Address: 3919 WEST FOSTER CHICAGO 60625</div> <div>County: COOK</div> <div>Telephone Number: (773) 588-9500 Fax # (773) 588-9533</div> <div>IDPA ID Number: 363969873001</div> <div>Date of Initial License for Current Owners: 12/14/94</div> <div>Type of Ownership:</div> <div><div><div><div></div><div>VOLUNTARY,NON-PROFIT</div><div></div><div>Charitable Corp.</div><div></div><div>Trust</div><div>IRS Exemption Code</div></div><div><div>X</div><div>PROPRIETARY</div><div></div><div>Individual</div><div></div><div>Partnership</div><div></div><div>Corporation</div><div>X</div><div>"Sub-S" Corp.</div><div></div><div>Limited Liability Co.</div><div></div><div>Trust</div><div></div><div>Other</div></div><div><div></div><div>GOVERNMENTAL</div><div></div><div>State</div><div></div><div>County</div><div></div><div>Other</div></div></div><div>In the event there are further questions about this report, please contact: Name:: Steve Lavenda Telephone Number: (847) 236 - 1111</div></div>	<div>II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER</div> <div>I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/02 to 12/31/02 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.</div> <div>Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.</div> <div><div>Officer or Administrator of Provider</div><div>(Signed) (Date)</div><div>(Type or Print Name)</div><div>(Title)</div><div>Paid Preparer</div><div>(Signed) See Accountants' Compilation Report Attached (Date)</div><div>(Print Name and Title) NOSHIR R. DARUWALLA, C.P.A.</div><div>(Firm Name & Address) Frost, Ruttenberg & Rothblatt, P.C. 111 Pfingsten Road, Suite 300 Deerfield, IL 60015</div><div>(Telephone) (847) 236-1111 Fax # (847) 236-1155</div><div>MAIL TO: OFFICE OF HEALTH FINANCE ILLINOIS DEPARTMENT OF PUBLIC AID 201 S. Grand Avenue East Springfield, IL 62763-0001 Phone # (217) 782-1630</div></div>
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SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number HARMONY NURSING AND REHAB

0040535 Report Period Beginning: 01/01/02 Ending: 12/31/02

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds N/A

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	<u>120</u>	Skilled (SNF)	<u>120</u>	<u>43,800</u>	1
2		Skilled Pediatric (SNF/PED)			2
3	<u>60</u>	Intermediate (ICF)	<u>60</u>	<u>21,900</u>	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	<u>180</u>	TOTALS	<u>180</u>	<u>65,700</u>	7

B. Census-For the entire report period.

	1	2	3	4	5	
	Level of Care	Patient Days by Level of Care and Primary Source of Payment				
		Public Aid Recipient	Private Pay	Other	Total	
8	SNF	<u>28,710</u>	<u>8,518</u>	<u>5,891</u>	<u>43,119</u>	8
9	SNF/PED					9
10	ICF	<u>14,709</u>	<u>5,249</u>		<u>19,958</u>	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	<u>43,419</u>	<u>13,767</u>	<u>5,891</u>	<u>63,077</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 96.01%

SEE ACCOUNTANTS' COMPILATION REPORT

D. How many bed-hold days during this year were paid by Public Aid? 923 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients. (E.g., day care, "meals on wheels", outpatient therapy) N/A

F. Does the facility maintain a daily midnight census? YES

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES ☐ NO ☒

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES ☐ NO ☒

I. On what date did you start providing long term care at this location?
Date started 12/14/94

J. Was the facility purchased or leased after January 1, 1978?
YES ☒ Date 05/25/94 NO ☐

K. Was the facility certified for Medicare during the reporting year?
YES ☒ NO ☐ If YES, enter number of beds certified 39 and days of care provided 5,891

Medicare Intermediary AdminaStar Federal

IV. ACCOUNTING BASIS

ACCRUAL ☒ MODIFIED CASH* ☐ CASH* ☐

Is your fiscal year identical to your tax year? YES ☒ NO ☐

Tax Year: 12/31/02 Fiscal Year: 12/31/02

* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number HARMONY NURSING AND REHAB # 0040535 Report Period Beginning: 01/01/02 Ending: 12/31/02

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass- ification 5	Reclassified Total 6	Adjust- ments 7	Adjusted Total 8	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	A. General Services											
1	Dietary	337,373	52,863	6,666	396,902		396,902	2,731	399,633			1
2	Food Purchase		326,831		326,831	(57,013)	269,818	(719)	269,099			2
3	Housekeeping	342,594	35,358		377,952		377,952	8,719	386,671			3
4	Laundry	74,820	29,333		104,153		104,153		104,153			4
5	Heat and Other Utilities			154,393	154,393		154,393	2,420	156,813			5
6	Maintenance	45,958	20,056	82,834	148,848		148,848	(20,918)	127,930			6
7	Other (specify):*											7
8	TOTAL General Services	800,745	464,441	243,893	1,509,079	(57,013)	1,452,066	(7,767)	1,444,299			8
	B. Health Care and Programs											
9	Medical Director			18,000	18,000		18,000		18,000			9
10	Nursing and Medical Records	2,327,494	132,294	30,588	2,490,376		2,490,376		2,490,376			10
10a	Therapy	193,725		220	193,945		193,945		193,945			10a
11	Activities	108,055	10,973	2,397	121,425		121,425		121,425			11
12	Social Services	167,092		4,653	171,745		171,745		171,745			12
13	Nurse Aide Training											13
14	Program Transportation			2,410	2,410		2,410		2,410			14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	2,796,366	143,267	58,268	2,997,901		2,997,901		2,997,901			16
	C. General Administration											
17	Administrative	87,687		208,000	295,687		295,687	34,003	329,690			17
18	Directors Fees											18
19	Professional Services			475,230	475,230	(13,153)	462,077	(367,931)	94,146			19
20	Dues, Fees, Subscriptions & Promotions			101,070	101,070		101,070	(55,026)	46,044			20
21	Clerical & General Office Expenses	181,252	5,300	192,567	379,119		379,119	14,010	393,129			21
22	Employee Benefits & Payroll Taxes			697,841	697,841	57,013	754,854		754,854			22
23	Inservice Training & Education											23
24	Travel and Seminar			7,185	7,185		7,185	73	7,258			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			174,840	174,840		174,840	595	175,435			26
27	Other (specify):*							43,808	43,808			27
28	TOTAL General Administration	268,939	5,300	1,856,733	2,130,972	43,860	2,174,832	(330,468)	1,844,363			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	3,866,050	613,008	2,158,894	6,637,952	(13,153)	6,624,799	(338,235)	6,286,563			29

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

SEE ACCOUNTANTS' COMPILATION REPORT

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total					9	10	
	D. Ownership	1	2	3	4	5	6	7	8			
30	Depreciation			36,800	36,800		36,800	449,233	486,033			30
31	Amortization of Pre-Op. & Org.							11,051	11,051			31
32	Interest			89,992	89,992		89,992	649,583	739,575			32
33	Real Estate Taxes					13,153	13,153	298,495	311,648			33
34	Rent-Facility & Grounds			1,348,560	1,348,560		1,348,560	(1,348,560)				34
35	Rent-Equipment & Vehicles			25,503	25,503		25,503	3,181	28,684			35
36	Other (specify):*							44,991	44,991			36
37	TOTAL Ownership			1,500,855	1,500,855	13,153	1,514,008	107,973	1,621,981			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers	230,439	198,983		429,422		429,422		429,422			39
40	Barber and Beauty Shops			16,815	16,815		16,815		16,815			40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			98,550	98,550		98,550		98,550			42
43	Other (specify):*	41,353			41,353		41,353	(41,353)	0			43
44	TOTAL Special Cost Centers	271,792	198,983	115,365	586,140		586,140	(41,353)	544,787			44
	GRAND TOTAL COST											
45	(sum of lines 29, 37 & 44)	4,137,842	811,991	3,775,114	8,724,947		8,724,947	(271,615)	8,453,332			45

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

SEE ACCOUNTANTS' COMPILATION REPORT

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7.
In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer- ence	3 OHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(10)	02		4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	256,031	30		9
10	Interest and Other Investment Income	(15,251)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(709)	02		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties	(866)	21		18
19	Entertainment				19
20	Contributions	(31,267)	20		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(106,506)	21		24
25	Fund Raising, Advertising and Promotional	(26,676)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(87,786)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (13,040)		\$	30

OHF USE ONLY							
48		49		50		51	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(258,575)		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (258,575)		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (271,615)		37

*These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.			\$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44	Exceptional Care Program					44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	TOTAL (C): (sum of lines 38-46)			\$		47

SEE ACCOUNTANTS' COMPILATION REPORT

STATE OF ILLINOIS		Page 5A
HARMONY NURSING AND REHAB		
ID# 0040335		
Report Period Beginning:	01/01/02	
Ending:	12/31/02	
		Sch. V Line
NON-ALLOWABLE EXPENSES		Amount Reference
1	BANK CHARGES	\$ (1,600) 21 1
2	NON ALLOWABLE LEGAL - RETAINER FEES	(12,028) 19 2
3	NON ALLOWABLE LEGAL - LOAN COSTS	(2,692) 19 3
4	KIERO BUILDING - FRANCHISE TAX	(200) 21 4
5	KIERO BUILDING - ACCOUNTING	(1,925) 19 5
6	KIERO BUILDING - TRUST FEES	(900) 21 6
7	COPY INCOME	(171) 21 7
8	MARKETING SALARY	(41,353) 43 8
9	CAPITALIZED REPAIRS AND MAINTENANCE	(24,077) 06 9
10	ICLTC (COPE)	(2,841) 20 10
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101	Total	(87,786) 101

Summary A

12/31/02

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

[illegible]

Summary B

Facility Name & ID Number	HARMONY NURSING AND REHAB	#	0040535	Report Period Beginning:	01/01/02	Ending:	12/31/02
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SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

[illegible]

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
SEE ATTACHED		SEE ATTACHED		SEE ATTACHED		

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☒ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
1	V	34	RENTAL INCOME	\$ 1,348,560	KEIRO BUILDING PARTNERSHIP	100.00%	\$	\$ (1,348,560)	1
2	V	32	INTEREST INCOME	14,915	KEIRO BUILDING PARTNERSHIP	100.00%		(14,915)	2
3	V	21	FRANCHISE TAX		KEIRO BUILDING PARTNERSHIP	100.00%	200	200	3
4	V	36	MIP INSURANCE		KEIRO BUILDING PARTNERSHIP	100.00%	44,991	44,991	4
5	V	19	ACCOUNTING		KEIRO BUILDING PARTNERSHIP	100.00%	1,925	1,925	5
6	V	21	TRUST FEES		KEIRO BUILDING PARTNERSHIP	100.00%	900	900	6
7	V	32	MORTGAGE INTEREST		KEIRO BUILDING PARTNERSHIP	100.00%	663,646	663,646	7
8	V	33	REAL ESTATE TAXES		KEIRO BUILDING PARTNERSHIP	100.00%	293,233	293,233	8
9	V	30	DEPRECIATION		KEIRO BUILDING PARTNERSHIP	100.00%	180,809	180,809	9
10	V	31	LOAN COST AMORTIZATION		KEIRO BUILDING PARTNERSHIP	100.00%	10,779	10,779	10
11	V								11
12	V								12
13	V								13
14	Total			\$ 1,363,475			\$ 1,196,483	\$ * (166,992)	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☒ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	1	DIETARY	\$	ITEX COMPANY / A.K. CARE	100.00%	\$ 2,731	\$	2,731 15
16	V	3	HOUSEKEEPING		ITEX COMPANY / A.K. CARE	100.00%	8,719		8,719 16
17	V	5	UTILITIES		ITEX COMPANY / A.K. CARE	100.00%	2,420		2,420 17
18	V	6	REPAIRS AND MAINT.		ITEX COMPANY / A.K. CARE	100.00%	3,159		3,159 18
19	V	19	PROFESSIONAL FEES		ITEX COMPANY / A.K. CARE	100.00%	4,487		4,487 19
20	V	20	FEES, SUBSCRIPTIONS		ITEX COMPANY / A.K. CARE	100.00%	362		362 20
21	V	21	CLERICAL AND GENERAL		ITEX COMPANY / A.K. CARE	100.00%	17,333		17,333 21
22	V	24	EDUCATION/SEMINARS		ITEX COMPANY / A.K. CARE	100.00%	38		38 22
23	V	26	INSURANCE		ITEX COMPANY / A.K. CARE	100.00%	595		595 23
24	V	27	EMPLOYEE BENEFITS		ITEX COMPANY / A.K. CARE	100.00%	332		332 24
25	V	30	DEPRECIATION		ITEX COMPANY / A.K. CARE	100.00%	12,393		12,393 25
26	V	31	AMORTIZATION		ITEX COMPANY / A.K. CARE	100.00%	272		272 26
27	V	32	INTEREST		ITEX COMPANY / A.K. CARE	100.00%	16,102		16,102 27
28	V	33	REAL ESTATE TAXES		ITEX COMPANY / A.K. CARE	100.00%	5,262		5,262 28
29	V	35	EQUIPMENT RENTAL		ITEX COMPANY / A.K. CARE	100.00%	3,181		3,181 29
30	V								30
31	V								31
32	V	21	CLERICAL SALARIES		ITEX COMPANY / A.K. CARE	100.00%	102,270		102,270 32
33	V	27	GEN ADMIN. - EMP. BEN.		ITEX COMPANY / A.K. CARE	100.00%	35,485		35,485 33
34	V								34
35	V	19	HOME OFFICE FEES	300,568	ITEX COMPANY / A.K. CARE	100.00%			(300,568) 35
36	V								36
37	V								37
38	V								38
39	Total			\$ 300,568			\$ 215,141	\$ *	(85,427) 39

* Total must agree with the amount recorded on line 34 of Schedule VI.

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☒ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	17	ADMINISTRATIVE	\$	CAREPATH HEALTH NETWORK	100.00%	\$ 34,003	\$ 34,003	15
16	V	19	PROFESSIONAL FEES		CAREPATH HEALTH NETWORK	100.00%	1,432	1,432	16
17	V	20	FEES, SUBSCRIPTIONS		CAREPATH HEALTH NETWORK	100.00%	5,395	5,395	17
18	V	21	CLERICAL AND GENERAL		CAREPATH HEALTH NETWORK	100.00%	3,550	3,550	18
19	V	24	SEMINARS		CAREPATH HEALTH NETWORK	100.00%	35	35	19
20	V	27	GEN ADMIN.- EMP. BEN.		CAREPATH HEALTH NETWORK	100.00%	7,991	7,991	20
21	V								21
22	V								22
23	V								23
24	V	19	HOME OFFICE FEES	58,562	CAREPATH HEALTH NETWORK	100.00%		(58,562)	24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$ 58,562			\$ 52,406	\$ * (6,156)	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V			\$			\$	\$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$			\$	\$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

☐

YES

☐

NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V			\$			\$	\$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$			\$	\$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

☐

YES

☐

NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V			\$			\$	\$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$			\$	\$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

☐ YES

☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V			\$			\$	\$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$			\$	\$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V			\$			\$	\$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$			\$	\$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

☐ YES

☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V			\$			\$	\$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$			\$	\$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

☐ YES

☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V		Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V			\$			\$	\$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			\$			\$	\$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	BERNARD HOLLANDER	OWNER	ADMIN	28.67%	SEE ATTACHED	7	10.77%		\$		1
2	MARK HOLLANDER	OWNER	ADMIN	9.56%	SEE ATTACHED	30	50.00%	MGMT FEES	183,000	17-03	2
3	JACK RAJCHENBACH	OWNER	ADMIN	28.67%	SEE ATTACHED	5	7.69%				3
4	ROBERT HARTMAN	OWNER	ADMIN	28.67%	SEE ATTACHED	3.25	5.00%				4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$ 183,000		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number HARMONY NURSING AND REHAB # 0040535 Report Period Beginning: 01/01/02 Ending: 12/31/02

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☒

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number
Fax Number

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	1	2	3	4	5	6	7	8	9	
	Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1						\$	\$			1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$	\$		\$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number HARMONY NURSING AND REHAB # 0040535 Report Period Beginning: 01/01/02 Ending: 12/31/02

VIII. ALLOCATION OF INDIRECT COSTS

Name of Related Organization ITEX COMPANY
Street Address 6633 N. LINCOLN AVE.
City / State / Zip Code LINCOLNWOOD, IL. 60712
Phone Number (847) 679-9141
Fax Number (847) 679-1820

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☒ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

	1	2	3	4	5	6	7	8	9	
	Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	1	DIETARY	AVAILABLE BED DAYS	463,355	5	\$ 19,263	\$	65,700	\$ 2,731	1
2	3	HOUSEKEEPING	AVAILABLE BED DAYS	463,355	5	61,490		65,700	8,719	2
3	5	UTILITIES	AVAILABLE BED DAYS	463,355	5	17,069		65,700	2,420	3
4	6	REPAIRS AND MAINT.	AVAILABLE BED DAYS	463,355	5	22,282		65,700	3,159	4
5	19	PROFESSIONAL FEES	AVAILABLE BED DAYS	463,355	5	31,647		65,700	4,487	5
6	20	FEES, SUBSCRIPTIONS	AVAILABLE BED DAYS	463,355	5	2,553		65,700	362	6
7	21	CLERICAL AND GENERAL	AVAILABLE BED DAYS	463,355	5	122,246		65,700	17,333	7
8	24	EDUCATION/SEMINARS	AVAILABLE BED DAYS	463,355	5	266		65,700	38	8
9	26	INSURANCE	AVAILABLE BED DAYS	463,355	5	4,194		65,700	595	9
10	27	EMPLOYEE BENEFITS	AVAILABLE BED DAYS	463,355	5	2,344		65,700	332	10
11	30	DEPRECIATION	AVAILABLE BED DAYS	463,355	5	87,403		65,700	12,393	11
12	31	AMORTIZATION	AVAILABLE BED DAYS	463,355	5	1,921		65,700	272	12
13	32	INTEREST	AVAILABLE BED DAYS	463,355	5	113,562		65,700	16,102	13
14	33	REAL ESTATE TAXES	AVAILABLE BED DAYS	463,355	5	37,112		65,700	5,262	14
15	35	EQUIPMENT RENTAL	AVAILABLE BED DAYS	463,355	5	22,434		65,700	3,181	15
16										16
17										17
18	21	CLERICAL SALARIES	DIRECT ALLOCATION		5	771,563	771,563		102,270	18
19	27	GEN ADMIN. - EMP. BEN.	DIRECT ALLOCATION		5	267,713			35,485	19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$ 1,585,062	\$ 771,563		\$ 215,141	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number HARMONY NURSING AND REHAB # 0040535 Report Period Beginning: 01/01/02 Ending: 12/31/02

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☒ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization CAREPATH HEALTH NETWORK
Street Address 6633 N LINCOLN AVENUE
City / State / Zip Code LINCOLNWOOD, IL 60712
Phone Number (888) 707-6700
Fax Number (847) 679-2150

	1	2	3	4	5	6	7	8	9	
	Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	17	ADMINISTRATIVE	CARE PATH FEES	617,442	13	\$ 358,512	\$ 358,512	58,562	\$ 34,003	1
2	19	PROFESSIONAL FEES	CARE PATH FEES	617,442	13	15,097		58,562	1,432	2
3	20	FEES, SUBSCRIPTIONS	CARE PATH FEES	617,442	13	56,887		58,562	5,395	3
4	21	CLERICAL AND GENERAL	CARE PATH FEES	617,442	13	37,424		58,562	3,550	4
5	24	SEMINARS	CARE PATH FEES	617,442	13	365		58,562	35	5
6	27	GEN ADMIN.- EMP. BEN.	CARE PATH FEES	617,442	13	84,255		58,562	7,991	6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$ 552,540	\$ 358,512		\$ 52,406	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number HARMONY NURSING AND REHAB # 0040535 Report Period Beginning: 01/01/02 Ending: 12/31/02

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number
Fax Number

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()

	1	2	3	4	5	6	7	8	9	
	Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1						\$	\$			1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$	\$		\$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number HARMONY NURSING AND REHAB # 0040535 Report Period Beginning: 01/01/02 Ending: 12/31/02

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number
Fax Number

()

()

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						\$	\$			1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$	\$		\$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number HARMONY NURSING AND REHAB # 0040535 Report Period Beginning: 01/01/02 Ending: 12/31/02

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number
Fax Number

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()

	1	2	3	4	5	6	7	8	9	
	Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1						\$	\$			1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$	\$		\$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number HARMONY NURSING AND REHAB # 0040535 Report Period Beginning: 01/01/02 Ending: 12/31/02

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number
Fax Number

()

()

	1	2	3	4	5	6	7	8	9	
	Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1						\$	\$			1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$	\$		\$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number HARMONY NURSING AND REHAB # 0040535 Report Period Beginning: 01/01/02 Ending: 12/31/02

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number
Fax Number

()

()

	1	2	3	4	5	6	7	8	9	
	Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1						\$	\$			1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$	\$		\$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number HARMONY NURSING AND REHAB # 0040535 Report Period Beginning: 01/01/02 Ending: 12/31/02

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number
Fax Number

()

()

	1	2	3	4	5	6	7	8	9	
	Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1						\$	\$			1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$	\$		\$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number HARMONY NURSING AND REHAB # 0040535 Report Period Beginning: 01/01/02 Ending: 12/31/02

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number
Fax Number

()

()

	1	2	3	4	5	6	7	8	9	
	Schedule V Line Reference	Item	Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1						\$	\$			1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$	\$		\$	25

SEE ACCOUNTANTS' COMPILATION REPORT

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

1		2		3	4	5	6		7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense		
		YES	NO				Original	Balance					
	A. Directly Facility Related												
	Long-Term												
1	CAMBRIDGE		X	MORTGAGE	\$61,990.00	10/01/97	\$ 9,317,100	\$ 8,961,561	10/01/32	7.38%	\$ 663,646	1	
2	HILL ROM		X	MEDICAL EQUIPMENT	\$593.00	03/15/00	12,856		02/15/02	10.00%	15	2	
3												3	
4												4	
5												5	
	Working Capital												
6	SHAREHOLDERS - ANB	X		WORKING CAPITAL			2,500,000	2,500,000		4.75%	54,706	6	
7												7	
8												8	
9	TOTAL Facility Related				\$62,583.00		\$ 11,829,956	\$ 11,461,561			\$ 718,367	9	
	B. Non-Facility Related*												
10	See Supplemental Schedule							255,679			35,856	10	
11	INTEREST INCOME										(15,251)	11	
12	INSURANCE FINANCING		X								531	12	
13	Small Purchase Financing		X								72	13	
14	TOTAL Non-Facility Related						\$	255,679			\$ 21,207	14	
15	TOTALS (line 9+line14)						\$ 11,829,956	\$ 11,717,240			\$ 739,574	15	

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ 44,991 Line # 36

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7.
(See instructions.)

SEE ACCOUNTANTS' COMPILATION REPORT

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2.
(See instructions.)

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6		7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense		
		YES	NO				Original	Balance					
1	GLENVIEW TERRACE	X		INTERCOMP EXCHANGE			\$	253,869		0.00%	\$	0	1
2	NUCARE/NUVISION	X		INTERCOMP EXCHANGE				1,810		0.00%		0	2
3	INTEREST INCOME - KEIRO	X										(14,915)	3
4	ALLOC. ITEX MGT/A.K. CARL	X										16,102	4
5	KEIRO BUILDING PARTNERS	X		INTERCOMP EXCHANGE								34,668	5
6													6
7													7
8													8
9													9
10													10
11													11
12													12
13													13
14													14
15													15
16													16
17													17
18													18
19													19
20													20
21							\$	255,679			\$	35,856	21

IMPORTANT NOTICE

TO:

Long Term Care Facilities with Real Estate Tax Rates

RE:

2001 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2001 real estate tax costs, as well as copies of your real estate tax bills for calendar 2001.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2001 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2002 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Office of Health Finance at (217) 782-1630.

2001 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME

HARMONY NURSING AND REHAB

COUNTY

COOK

FACILITY IDPH LICENSE NUMBER

0040535

CONTACT PERSON REGARDING THIS REPORT

STEVE LAVENDA

TELEPHONE

(847)-236-1111

FAX #:

(847)-236-1155

- A. Summary of Real Estate Tax Cost
- Enter the tax index number and real estate tax assessed for 2001 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2001.

	(A)	(B)	(C)	(D)
	<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	<u>Tax</u> <u>Applicable to</u> <u>Nursing Home</u>
1.	13-11-300-007-0000	NURSING HOME	\$ 337,175.74	\$ 337,175.74
2.	10-35-329-014-0000	CENTRAL OFFICE	\$ 39,312.21	\$ 5,328.00
3.			\$	\$
4.			\$	\$
5.			\$	\$
6.			\$	\$
7.			\$	\$
8.			\$	\$
9.			\$	\$
10.			\$	\$
		TOTALS	\$ 376,487.95	\$ 342,503.74

- B. Real Estate Tax Cost Allocations
- Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? X YES NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home.
(Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)
- C. Tax Bills
- Attach a copy of the 2001 tax bills which were listed in Section A to this statement. Be sure to use the 2001 tax bill which is normally paid during 2002.

IMPORTANT NOTICE

TO:

Long Term Care Facilities with Real Estate Tax Rates

RE:

2000 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2000 real estate tax costs, as well as copies of your real estate tax bills for calendar 2000.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2000 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2001 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Office of Health Finance at (217) 782-1630.

2000 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME

HARMONY NURSING AND REHAB

COUNTY

COOK

FACILITY IDPH LICENSE NUMBER

0040535

CONTACT PERSON REGARDING THIS REPORT

TELEPHONE ()

FAX #: ()

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2000 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2000.

(A)	(B)	(C)	(D)
Tax Index Number	Property Description	Total Tax	<u>Tax</u> Applicable to Nursing Home
1.		\$	\$
2.		\$	\$
3.		\$	\$
4.		\$	\$
5.		\$	\$
6.		\$	\$
7.		\$	\$
8.		\$	\$
9.		\$	\$
10.		\$	\$
TOTALS		\$	\$

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? YES NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home.
(Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. **Tax Bills**

Attach a copy of the 2000 tax bills which were listed in Section A to this statement. Be sure to use the 2000 tax bill which is normally paid during 2001.

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 64,216

B. General Construction Type: Exterior MASONARY

Frame STEEL

Number of Stories FOUR

C. Does the Operating Entity?

☐ (a) Own the Facility

☒ (b) Rent from a Related Organization.

☐ (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity?

☒ (a) Own the Equipment

☒ (b) Rent equipment from a Related Organization.

☒ (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

NONE

F. Does this cost report reflect any organization or pre-operating costs which are being amortized?

☒ YES

☐ NO

If so, please complete the following:

1. Total Amount Incurred: 377,250

2. Number of Years Over Which it is Being Amortized: 35

3. Current Period Amortization: 11,051

4. Dates Incurred: 1997

Nature of Costs: KEIRO BUILDING LLC= \$ 10,779, ALLOCATION FROM ITEX MNGMT. / A.K. CARE = \$ 272

(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	FACILITY		1994	\$ 600,000	1
2					2
3	TOTALS			\$ 600,000	3

SEE ACCOUNTANTS' COMPILATION REPORT

XI. OWNERSHIP COSTS (continued)
B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1	2	3	4	5	6	7	8	9		
	Beds*	FOR OHF USE ONLY	Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4					\$	\$		\$	\$	\$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Various			1994	11,156		20	621	621	4,934	9
10	Various			1996	9,553		20	477	477	3,238	10
11	Various			1997	8,612		20	431	431	2,491	11
12	Various			1998	12,911		20	646	646	2,973	12
13								-		-	13
14								-		-	14
15								-		-	15
16								-		-	16
17								-		-	17
18								-		-	18
19								-		-	19
20								-		-	20
21								-		-	21
22								-		-	22
23								-		-	23
24								-		-	24
25								-		-	25
26								-		-	26
27								-		-	27
28								-		-	28
29								-		-	29
30								-		-	30
31								-		-	31
32								-		-	32
33								-		-	33
34								-		-	34
35								-		-	35
36								-		-	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A, Line 70 for total

SEE ACCOUNTANTS' COMPILATION REPORT

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37		\$	\$		\$ -	\$	\$ -	37
38					-		-	38
39					-		-	39
40					-		-	40
41					-		-	41
42					-		-	42
43					-		-	43
44					-		-	44
45					-		-	45
46					-		-	46
47					-		-	47
48					-		-	48
49					-		-	49
50					-		-	50
51					-		-	51
52					-		-	52
53					-		-	53
54					-		-	54
55					-		-	55
56					-		-	56
57					-		-	57
58					-		-	58
59					-		-	59
60					-		-	60
61					-		-	61
62					-		-	62
63					-		-	63
64					-		-	64
65					-		-	65
66					-		-	66
67					-		-	67
68	Related Party Allocations (Page 12-REP & Page 12A-REP)	7,318,263	187,515		361,039	173,524	2,907,184	68
69	Financial Statement Depreciation		10,336			(10,336)		69
70	TOTAL (lines 4 thru 69)	\$ 7,360,495	\$ 197,851		\$ 363,214	\$ 165,363	\$ 2,920,820	70

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1	2	3	4	5	6	7	8	9	10
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		\$ 7,360,495	\$ 197,851		\$ 363,214	\$ 165,363	\$ 2,920,820	1
2	CHAIN LINK FENCE	1999	1,879		20	94	94	368	2
3	FIRE DAMPERS	1999	8,775		20	439	439	1,683	3
4	FIRE DAMPERS	1999	2,200		20	110	110	413	4
5	FENCE	1999	1,389		20	69	69	253	5
6	OUTSIDE HYDRANTS	1999	2,455		20	123	123	431	6
7	TRANSFER SWITCHES	1999	37,000		20	1,850	1,850	6,938	7
8	DOORS	1999	1,947		20	97	97	380	8
9	DOORS	1999			20				9
10	VINYL	1999	522		20	26	26	93	10
11	WATER HEATER-16 GAL.	1999	129		20	6	6	20	11
12	DOOR CLOSER	1999	630		20	32	32	125	12
13	FIRE ALARM RELAY BOA	1999	1,130		20	57	57	185	13
14	AIR CONDITIONER	1999	1,104		20	55	55	193	14
15	AIR CONDITIONER	1999	2,208		20	110	110	376	15
16	BEDSIDE CABINET	1999			20				16
17	EMERGENCY SYSTEM	2000	19,300		20	965	965	2,332	17
18	DOORLOCK SAFETY	2000	1,174		20	59	59	118	18
19	WATER BOILER	2000	1,486		20	74	74	148	19
20	WALLPAPER VINYL	2000	904		20	45	45	90	20
21	WINDOW SYSTEM	2000	647		20	32	32	64	21
22	LIGHTING	2000	1,174		20	59	59	118	22
23	WOODEN HOOK-UP	2000	1,737		20	87	87	174	23
24	BOILER DAMPER	2000	3,405		20	170	170	340	24
25	DSL CABLE WIRE	2000	1,035		20	52	52	104	25
26	RADIATOR	2000	2,001		20	100	100	200	26
27	THERMOSTAT	2000	2,548		20	127	127	254	27
28	COMMUNICATION	2000	1,260		20	63	63	126	28
29	FOX VALLEY HEATING	2001	11,600		20	580	580	773	29
30	LOCKS	2001	559		20	28	28	37	30
31	LOCKS	2001	559		20	28	28	30	31
32	AC REPAIRS	2001	1,231		20	62	62	88	32
33	DOOR	2001	613		20	31	31	39	33
34	TOTAL (lines 1 thru 33)		\$ 7,473,096	\$ 197,851		\$ 368,844	\$ 170,993	\$ 2,937,313	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1	2	3	4	5	6	7	8	9	10
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12B, Carried Forward		\$ 7,473,096	\$ 197,851		\$ 368,844	\$ 170,993	\$ 2,937,313	1
2	PARKING LOT SEALCOAT	2001	3,500		20	175	175	233	2
3	COOLER - LOCK BAR	2001	789		20	39	39	42	3
4	SMOKE DETECTOR	2001	645		20	32	32	61	4
5	SINGLE & DUAL JACK	2001	581		20	29	29	46	5
6	FIRE EQUIPMENT	2001	1,695		20	85	85	120	6
7	CHICAGO SOUND & COMMUNICATION	2002	5,000		20	667	667	667	7
8	CHICAGO SOUND & COMMUNICATION	2002	2,500		20	292	292	292	8
9	WATER HEATER	2002	2,599		20	126	126	126	9
10	CHGO SOUND & COMMUNICATION	2002	2,495		20	166	166	166	10
11	WINDOWS	2002	647		20	30	30	30	11
12	WINDOWS	2002	647		20	24	24	24	12
13	WINDOWS	2002	705		20	23	23	23	13
14	SIGNS	2002	537		20	18	18	18	14
15	WINDOWS	2002	647		20	13	13	13	15
16	WINDOWS	2002	705		20	15	15	15	16
17	WINDOWS	2002	1,952		20	24	24	24	17
18	WINDOWS	2002	1,988		20	17	17	17	18
19	WINDOWS	2002	649		20	3	3	3	19
20	THERMOSTATE	2002	1,330		20	6	6	6	20
21	CALL SYSTEM	2002	779		20	45	45	45	21
22	FREEZER DOOR	2002	549		20	11	11	11	22
23	FREEZER	2002	634		20	8	8	8	23
24	COOLER - CONDENSOR	2002	508		20	4	4	4	24
25	COOLER - COMPRESSER	2002	802		20	3	3	3	25
26	CALL SYSTEM	2002	523		20	22	22	22	26
27	CENTRAL AIR/C	2002	1,664		20	35	35	35	27
28	SMOKE DETECTOR	2002	536		20	7	7	7	28
29	SMOKE DETECTOR	2002	523		20	4	4	4	29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$ 7,509,224	\$ 197,851		\$ 370,767	\$ 172,916	\$ 2,939,378	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1 Improvement Type**		3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12C, Carried Forward		\$7,509,224	\$197,851		\$370,767	\$172,916	\$2,939,378	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
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23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$7,509,224	\$197,851		\$370,767	\$172,916	\$2,939,378	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1 Improvement Type**		3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12D, Carried Forward		\$7,509,224	\$197,851		\$370,767	\$172,916	\$2,939,378	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
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19									19
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21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$7,509,224	\$197,851		\$370,767	\$172,916	\$2,939,378	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1 Improvement Type**		3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12E, Carried Forward		\$7,509,224	\$197,851		\$370,767	\$172,916	\$2,939,378	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$7,509,224	\$197,851		\$370,767	\$172,916	\$2,939,378	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1 Improvement Type**		3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12F, Carried Forward		\$7,509,224	\$197,851		\$370,767	\$172,916	\$2,939,378	1
2									2
3									3
4									4
5									5
6									6
7									7
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25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$7,509,224	\$197,851		\$370,767	\$172,916	\$2,939,378	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1 Improvement Type**		3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12G, Carried Forward		\$7,509,224	\$197,851		\$370,767	\$172,916	\$2,939,378	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
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24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$7,509,224	\$197,851		\$370,767	\$172,916	\$2,939,378	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1 Improvement Type**		3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12H, Carried Forward		\$7,509,224	\$197,851		\$370,767	\$172,916	\$2,939,378	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
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23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$7,509,224	\$197,851		\$370,767	\$172,916	\$2,939,378	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1 Improvement Type**		3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12I, Carried Forward		\$7,509,224	\$197,851		\$370,767	\$172,916	\$2,939,378	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
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24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$7,509,224	\$197,851		\$370,767	\$172,916	\$2,939,378	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1 Improvement Type**		3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12I, Carried Forward		\$7,509,224	\$197,851		\$370,767	\$172,916	\$2,939,378	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
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10									10
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26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		\$7,509,224	\$197,851		\$370,767	\$172,916	\$2,939,378	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1	FOR OHF USE ONLY	2	3	4	5	6	7	8	9	
	Beds*		Year Acquired	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
4			1994		\$ 7,019,409	\$ 179,985	20	\$ 350,970	\$ 170,985	\$ 2,814,872	4
5			1993		227,442	5,832	35	6,498	666	62,275	5
6											6
7											7
8											8
	Improvement Type**										
9	ALLOCATION - ITEX MANAGEMENT			1993	28,619	346	20	1,431	1,085	13,889	9
10	ALLOCATION - ITEX MANAGEMENT			1994	15,372	400	20	769	369	6,365	10
11	ALLOCATION - ITEX MANAGEMENT			1995	2,620	95	20	131	36	943	11
12	ALLOCATION - ITEX MANAGEMENT			1996	148	13	20	7	6	52	12
13	ALLOCATION - ITEX MANAGEMENT			1997	4,419	113	20	221	108	1,215	13
14	ALLOCATION - ITEX MANAGEMENT			1999	491	13	20	25	12	98	14
15	ALLOCATION - KEIRO BUILDING, LLC			1995	19,743	718	20	987	269	7,475	15
16											16
17											17
18											18
19											19
20											20
21											21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36											36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A-REP, Line 70 for total

SEE ACCOUNTANTS' COMPILATION REPORT

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1 Improvement Type**		3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37			\$	\$		\$	\$	\$	37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
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64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		\$7,318,263	\$187,515		\$361,039	\$173,536	\$2,907,184	70

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$1,131,468	\$29,032	\$113,051	\$84,019	10	\$865,128	71
72	Current Year Purchases	32,300	3,119	2,215	(904)	10	2,215	72
73	Fully Depreciated Assets	17,760				10	17,759	73
74								74
75	TOTALS	\$1,181,528	\$32,151	\$115,266	\$83,115		\$885,102	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76				\$	\$	\$	\$		\$	76
77										77
78										78
79										79
80	TOTALS			\$	\$	\$	\$		\$	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$9,290,752	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$230,002	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$486,033	83
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$256,031	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$3,824,480	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		\$	\$	\$	86
87					87
88					88
89					89
90					90
91	TOTALS	\$	\$	\$	91

G. Construction-in-Progress

	Description	Cost	
92		\$	92
93			93
94			94
95		\$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A
2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions.
- ☒ YES☐ NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				\$			3
4	Additions							4
5								5
6								6
7	TOTAL				\$			7

**

8. List separately any amortization of lease expense included on page 4, line 34.

This amount was calculated by dividing the total amount to be amortized
by the length of the lease .

9. Option to Buy: ☐ YES ☐ NO Terms: *

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental?
☐ YES ☒ NO
16. Rental Amount for movable equipment: \$ 12,054 Description: Pitney Bowes(Postage Meter) \$2,162,Cannon Financial (Copier) \$ 6,711,ITEX \$ 3,181
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17	FACILITY	INFINITI	\$ #####	\$ 16,630	17
18					18
19					19
20					20
21	TOTAL		\$ #####	\$ 16,630	21

10. Effective dates of current rental agreement:

Beginning
Ending

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2003	\$
13.	/2004	\$
14.	/2005	\$

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD?

☐ YES

☒ NO

If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:

IN-HOUSE PROGRAM

IN OTHER FACILITY

COMMUNITY COLLEGE

HOURS PER AIDE

3. CLINICAL PORTION:

IN-HOUSE PROGRAM

IN OTHER FACILITY

HOURS PER AIDE

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	\$	\$	\$	\$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests				
9	TOTALS	\$	\$	\$	\$
10	SUM OF line 9, col. 1 and 2 (e)	\$			

- (a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
- (b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
- (c) For in-house training programs only. Do not include fringe benefits.
- (d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

\$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

- (e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
- (f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.
- SEE ACCOUNTANTS' COMPILATION REPORT

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	39 - 01	hrs	\$ 69,420		\$	\$		\$ 69,420	1
2	Licensed Speech and Language Development Therapist	39 - 01	hrs	25,440					25,440	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39 - 01	hrs	135,579					135,579	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39 - 02	# of prescripts				157,591		157,591	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify): See Supplemental						41,392		41,392	13
14	TOTAL			\$ 230,439		\$	\$ 198,983		\$ 429,422	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

SEE ACCOUNTANTS' COMPILATION REPORT

This report must be completed even if financial statements are attached.

		1	2	
		Operating	After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 263,518	\$ 588,085	1
2	Cash-Patient Deposits	56,212	56,212	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	2,086,823	2,086,823	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	137,141	174,349	6
7	Other Prepaid Expenses	314,084	314,084	7
8	Accounts Receivable (owners or related parties)	739,467	723,340	8
9	Other(specify): See Supplemental Schedule	11,150	614,360	9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ 3,608,395	\$ 4,557,253	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		600,000	13
14	Buildings, at Historical Cost		7,019,409	14
15	Leasehold Improvements, at Historical Cost	104,518	107,918	15
16	Equipment, at Historical Cost	217,673	1,141,156	16
17	Accumulated Depreciation (book methods)	(168,374)	(2,539,119)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs		377,250	19
20	Accumulated Amortization - Organization & Pre-Operating Costs		(56,588)	20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): See Supplemental Schedule			23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 153,817	\$ 6,650,026	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 3,762,212	\$ 11,207,279	25

		1	2	
		Operating	After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 236,845	\$ 299,420	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	55,272	55,272	28
29	Short-Term Notes Payable	2,755,679	2,755,679	29
30	Accrued Salaries Payable	127,016	127,016	30
31	Accrued Taxes Payable (excluding real estate taxes)	19,301	19,301	31
32	Accrued Real Estate Taxes(Sch.IX-B)		354,035	32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes	30,404	30,404	35
	Other Current Liabilities(specify):			
36	See Supplemental Schedule	72,880	72,880	36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 3,297,397	\$ 3,714,007	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable		8,961,561	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	See Supplemental Schedule			43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$	\$ 8,961,561	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 3,297,397	\$ 12,675,568	46
47	TOTAL EQUITY(page 18, line 24)	\$ 464,815	\$ (1,468,289)	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 3,762,212	\$ 11,207,279	48

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ (631,405)	1
2	Restatements (describe):		2
3	DEPRECIATION ADJUSTMENT	27,321	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ (604,084)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	400,228	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants	893,671	11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	(225,000)	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ 1,068,899	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ 464,815	24 *

* This must agree with page 17, line 47.

SEE ACCOUNTANTS' COMPILATION REPORT

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.
Note: This schedule should show gross revenue and expenses. Do not net revenue against expense

	Revenue	Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	\$ 8,529,053	1
2	Discounts and Allowances for all Levels	(520,558)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 8,008,495	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	742,970	6
7	Oxygen	1,690	7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 744,660	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care	17,701	13
14	Non-Patient Meals		14
15	Telephone, Television and Radio	8,593	15
16	Rental of Facility Space		16
17	Sale of Drugs	213,075	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	47,193	19
20	Radiology and X-Ray		20
21	Other Medical Services	70,026	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 356,588	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	15,251	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 15,251	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	<u>See Supplemental Schedule</u>	181	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$ 181	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 9,125,175	30

	Expenses	Amount	
	A. Operating Expenses		
31	General Services	1,509,079	31
32	Health Care	2,997,901	32
33	General Administration	2,130,972	33
	B. Capital Expense		
34	Ownership	1,500,855	34
	C. Ancillary Expense		
35	Special Cost Centers	487,590	35
36	Provider Participation Fee	98,550	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 8,724,947	40
41	Income before Income Taxes (line 30 minus line 40)**	400,228	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ 400,228	43

* This must agree with page 4, line 45, column 4.

** Does this agree with taxable income (loss) per Federal Income Tax Return? CASH BASIS If not, please attach a reconciliation.

*** See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation. SEE ACCOUNTANTS' COMPILATION REPORT

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.

Facility Name & ID Number HARMONY NURSING AND REHAB

0040535

Report Period Beginning:

01/01/02

Ending:

12/31/02

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)

(This schedule must cover the entire reporting period.)

		1	2**	3	4	
		# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage	
1	Director of Nursing	1,690	1,723	\$ 76,753	\$ 44.56	1
2	Assistant Director of Nursing	1,991	2,332	62,482	26.80	2
3	Registered Nurses	37,564	40,994	842,636	20.56	3
4	Licensed Practical Nurses	9,596	10,185	194,834	19.13	4
5	Nurse Aides & Orderlies	116,085	122,571	1,037,529	8.46	5
6	Nurse Aide Trainees					6
7	Licensed Therapist	7,801	7,933	230,439	29.05	7
8	Rehab/Therapy Aides	17,349	17,548	193,725	11.04	8
9	Activity Director	1,679	1,823	29,115	15.97	9
10	Activity Assistants	8,671	9,515	78,940	8.30	10
11	Social Service Workers	11,320	12,400	167,092	13.48	11
12	Dietician					12
13	Food Service Supervisor	2,991	3,159	64,656	20.47	13
14	Head Cook	2,799	3,110	28,696	9.23	14
15	Cook Helpers/Assistants	31,795	33,540	244,021	7.28	15
16	Dishwashers					16
17	Maintenance Workers	3,229	3,407	45,958	13.49	17
18	Housekeepers	40,109	43,153	342,594	7.94	18
19	Laundry	9,210	9,952	74,820	7.52	19
20	Administrator	1,858	2,138	87,687	41.01	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	14,219	15,108	181,252	12.00	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	7,954	8,868	113,260	12.77	31
32	Other Health Care(specify)					32
33	Other(specify) <u>See Supplemental</u>	1,751	1,945	41,353	21.26	33
34	TOTAL (lines 1 - 33)	329,662	351,403	\$ 4,137,842 *	\$ 11.78	34

B. CONSULTANT SERVICES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference	
35	Dietary Consultant	MONTHLY	\$ 6,666	01-03	35
36	Medical Director	MONTHLY	18,000	09-03	36
37	Medical Records Consultant	MONTHLY	4,788	10-03	37
38	Nurse Consultant	MONTHLY	24,000	10-03	38
39	Pharmacist Consultant	MONTHLY	1,800	10-03	39
40	Physical Therapy Consultant	4	220	10a-03	40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	51	2,397	11-03	44
45	Social Service Consultant	90	4,653	12-03	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	145	\$ 62,524		49

C. CONTRACT NURSES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses		\$		50
51	Licensed Practical Nurses				51
52	Nurse Aides				52
53	TOTAL (lines 50 - 52)		\$		53

SEE ACCOUNTANTS' COMPILATION REPORT

* This total must agree with page 4, column 1, line 45.

** See instructions.

XIX. SUPPORT SCHEDULES

A. Administrative Salaries				D. Employee Benefits and Payroll Taxes				F. Dues, Fees, Subscriptions and Promotions			
Name	Function	%	Amount	Description		Amount	Description		Amount		
JOHN MARC SIANGIO	ADMINISTRATOR	0	\$ 87,687	Workers' Compensation Insurance		\$ 53,997	IDPH License Fee		\$ 200		
				Unemployment Compensation Insurance		38,224	Advertising: Employee Recruitment		6,517		
				FICA Taxes		313,014	Health Care Worker Background Check		1,859		
				Employee Health Insurance		233,084	(Indicate # of checks performed 188)				
				Employee Meals		57,013	RECRUITMENT FEES		22,500		
				Illinois Municipal Retirement Fund (IMRF)*			ASSOCIATION DUES		7,203		
				HEAD TAX		9,070	PUBLIC RELATIONS AND ADVERTISING		26,676		
				EMPLOYEE PENSION		38,572	DUES AND SUBSCRIPTIONS		674		
				MISCELLANEOUS EMPLOYEE BENEFITS		4,882	LICENSE AND PERMITS		1,334		
				HOLIDAY EXPENSE		6,999	ALLOC. ITEX A.K. CARE/CAREPATH		5,757		
							Less: Public Relations Expense		(26,336)		
							Non-allowable advertising		(340)		
							Yellow page advertising ()		
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)						\$ 87,687	TOTAL (agree to Sch. V, line 20, col. 8)		\$ 46,044		
B. Administrative - Other											
Description			Amount								
MARK HOLLANDER - MANAGEMENT FEES			\$ 208,000								
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)			\$ 208,000								
C. Professional Services											
Vendor/Payee	Type		Amount	Description		Line #	Amount	Description		Amount	
A.K. CARE	BKKPING / DATA PROC.		\$ 252,568					Out-of-State Travel		\$	
CARE PATH	BKKPING / DATA PROC.		106,562								
F R & R	ACCOUNTING		24,595								
								In-State Travel			
SUSAN FOX	ACCOUNTING		14,940								
JOINT COMMISSION	ACCREDITATION		2,932								
PERSONNEL PLANNERS	UNEMP. CONSULTANT		2,265								
GIFTRAP CORP.	DATA PROCESSING		2,594					Seminar Expense		7,185	
HORIZON HEALTHCARE	DATA PROCESSING		8,002					ALLOC. CAREPATH		35	
POWER SOFTWARE DEVEL	DATA PROCESSING		7,031					ALLOC. ITEX MGMT./A.K. CARE		38	
MEDI.COM	DATA PROCESSING		85								
SEE SCHEDULE ATTACHED	LEGAL		53,656					Entertainment Expense ()	
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed \$2500 attach copy of invoices.)						\$ 475,230	TOTAL (agree to Sch. V, line 24, col. 8)		\$ 7,258		

*** Attach copy of IMRF notifications
SEE ACCOUNTANTS' COMPILATION REPORT**

****See instructions.**

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY1999	FY2000	FY2001	FY2002	FY2003	FY2004	FY2005	FY2006	FY2007
1	N/A		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number		HARMONY NURSING AND REHAB		STATE OF ILLINOIS	#	0040535	Report Period Beginning:	01/01/02	Ending:	12/31/02	Page 23
XX. GENERAL INFORMATION:											
(1)	Are nursing employees (RN,LPN,NA) represented by a union?			YES							
(2)	Are there any dues to nursing home associations included on the cost report?			YES							
	If YES, give association name and amount.			ICLTC \$7,203							
(3)	Did the nursing home make political contributions or payments to a political action organization?			YES							
	If YES, have these costs been properly adjusted out of the cost report?			YES							
(4)	Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year?			NO							
	If YES, what is the capacity?										
(5)	Have you properly capitalized all major repairs and equipment purchases?			YES							
	What was the average life used for new equipment added during this period?			10							
(6)	Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V.			\$ 11,801 Line 10-02							
(7)	Have all costs reported on this form been determined using accounting procedures consistent with prior reports?			YES							
	If NO, attach a complete explanation.										
(8)	Are you presently operating under a sale and leaseback arrangement?			NO							
	If YES, give effective date of lease.										
(9)	Are you presently operating under a sublease agreement?			YES X NO							
(10)	Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)?			YES NO X							
	If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.										
(11)	Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period.			\$ 98,550							
	This amount is to be recorded on line 42 of Schedule V.										
(12)	Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee?			NO							
	If YES, attach an explanation of the allocation.										
SEE ACCOUNTANTS' COMPILATION REPORT											
(13)	Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V?			YES							
(14)	Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B?			NO							
	For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.										
(15)	Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V.			\$ 57,013							
	Has any meal income been offset against related costs?			NO							
	Indicate the amount.			\$							
(16)	Travel and Transportation										
	a. Are there costs included for out-of-state travel?			NO							
	If YES, attach a complete explanation.										
	b. Do you have a separate contract with the Department to provide medical transportation for residents?			NO							
	If YES, please indicate the amount of income earned from such a program during this reporting period.			\$							
	c. What percent of all travel expense relates to transportation of nurses and patients?			100%in14							
	d. Have vehicle usage logs been maintained?			N/A							
	e. Are all vehicles stored at the nursing home during the night and all other times when not in use?			N/A							
	f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report?			YES							
	g. Does the facility transport residents to and from day training?			NO							
	Indicate the amount of income earned from providing such transportation during this reporting period.			\$ N/A							
(17)	Has an audit been performed by an independent certified public accounting firm?			NO							
	Firm Name:										
	The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached?										
	If no, please explain.										
(18)	Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V?			YES							
(19)	If total legal fees are in excess of \$2500, have legal invoices and a summary of services performed been attached to this cost report?			YES							
	Attach invoices and a summary of services for all architect and appraisal fees										